

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

CERTIFICATE OF DEATH

Reg. Dist. No. 03139 2510

1. PLACE OF DEATH:

County.....92d
 City or town.....Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....11 yrs
 Hospital, institution, or street address where death occurred:
W
 How long in hospital or institution?.....—

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Ind. County.....92d
 City or town.....Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....—
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Adam J. Hadzicki (deas) Harry J. Burke

3. (b) Social Security Number

219-07-05394. Sex.....M 5. Color or race.....W 6.(a) Single, married, widowed, or divorced.....Married6.(b) Name of husband or wife.....Clara Hadzicki7. Birth date of deceased (mo., day, yr.).....July 10, 18826.(c) If alive, give age.....62 years8. AGE: Years.....64 Months.....8 Days.....5 If less than one day..... hrs. min.9. Birthplace.....Balt Md
(Town, county, and state)10. Usual occupation.....None11. Industry or business.....—12. Name.....P. Henry Hadzicki13. Birthplace.....Poland14. Maiden name.....Clara Kotars15. Birthplace.....Poland16. Informant.....Clara HadzickiAddress.....3127 Chestnut Hill Ave, Balt Md17. Burial (Burial, cremation, or removal. Which?) Date thereof.....Mar. 18 47
(month) (day) (year)Cemetery or crematory.....TemplevilleLocation.....Templeville Ind18. Funeral director.....Edgar L. KaneAddress.....Church Hill Ind.19. 3-17 47 Edgar L. Kane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....July 15 19 47, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19 40, to July 15 19 47and that I last saw him alive on July 14 19 47Immediate cause of death.....Coronary occlusion

DURATION

Due to.....Coronary sclerosisDue to.....Ch. Myocarditis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....W

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....C. N. Uptcalfe M. D. or otherAddress.....Post Office Ind. Date signed.....3/17/47

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

CORONER'S OFFICE

RECEIVED
MAR 22 1947
BUREAU

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-21

CERTIFICATE OF DEATH

Reg. Dist. No. 03140 2540

1. PLACE OF DEATH:

County Queen Anne
 City or town Rural Grasonville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Queen Anne
 City or town Rural Grasonville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Sara Matilda Butler

3. (b) Social Security Number

4. Sex F 5. Color or race C 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Charles Henry Butler
 6. (c) If alive, give age 70 years
 7. Birth date of deceased (mo., day, yr.) July 7 1886
 8. AGE: Years 61 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Queenstown Maryland
(Town, county, and state)10. Usual occupation House work

11. Industry or business

MOTHER FATHER
 12. Name Robert Lloyd
 13. Birthplace Maryland
 14. Maiden name Mary Ellen Murray
 15. Birthplace Maryland

16. Informant Charles Henry Butler
 Address Rural Grasonville Md

17. Burial Date thereof April 13 1947
 (Burial, cremation, or removal. Which?) (Month) (day) (year)

Cemetery or crematory Home Excelsior Shipyards
 Location Queenstown, Prince Georges Co Md

18. Funeral director John D. Williams
 Address Belair Md

19. March 29 1947 Nolan M. Aedridge
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 2 1947 to March 28 1947
 and that I last saw her alive on March 28 1947

Immediate cause of death Hypertensive Cardiovascular
Renal Disease
 DURATION 2 mos

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William C. Rowe, M.D.

M. D. or other

Address Queenstown, Md Date signed March 29 1947

MARGIN RESERVED FOR BINDING

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03141



Reg. Dist. No. 2540

1. PLACE OF DEATH:
 County Queen Anne's
 City or town Grasonville (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Queen Anne's
 City or town Grasonville (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(c) If veteran, name war

3. (a) FULL NAME James S. Carter

3. (b) Social Security Number
219-83-7546

4. Sex male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Melvina Hedricks

7. Birth date of deceased (mo., day, yr.) May 20, 1885 6. (c) If alive, give age deceased years

8. AGE: Years 61 Months 9 Days 18 If less than one day hrs. min.

9. Birthplace Grasonville Md
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Waterman

12. Name Wm. Carter

13. Birthplace Virginia

14. Maiden name Mary Eleza Scott

15. Birthplace Queen Anne Co. Md

18. Informant James T. Carter

Address Grasonville, Md

17. Burial Date thereof Mar. 13, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bryan Chapel Cemetery

Location Grasonville, Md

18. Funeral director John D. Williams

Address Barton, Md.

19. March 10, 1947 Helen M. Aldridge
 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10th 19 47, at 2 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 10 19 46 to March 10 19 47.

and that I last saw him alive on March 9 19 47.

Immediate cause of death

coronary sclerosis angina pectoris coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Theodor Sattelmeier M.D.

Address Stevensville

Date signed 3/10/47

DURATION

Oct. 10, 1946

March 10

1947

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MAR 14 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89a

CERTIFICATE OF DEATH

Reg. Dist. No. 01314 251

1. PLACE OF DEATH

County Green AnneCity or town Ind. Inglewade
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Green AnneCity or town Ind. Inglewade
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Martha Dean

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Col.

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Chas. Dean6.(c) If alive, give age 52 years

7. Birth date of

deceased (mo., day, yr.)

Dec. 27-1903

8. AGE:

Years

43

Months

3

Days

2

If less than one day

_____ hrs. _____ min.

9. Birthplace

Green Anne Co. Ind.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Dean Gardner

13. Birthplace

Ind.

14. Maiden name

Unknown

15. Birthplace

"

16. Informant

Mr. Charles Dean

Address

Church Hill Ind.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Mar. 31-47
(month) (day) (year)

Cemetery or crematory

Rossville Cem.

Location

Rossville Ind.

18. Funeral director

Edgar R. Lane

Address

Church Hill Ind.

19.

Mar. 29
(Date rec'd by registrar)19. 47Edgar R. Lane

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 47 at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 27 1947 to Feb 29 1947and that I last saw him alive on Feb 29 1947

Immediate cause of death

Heart Blood Pressure

Due to

Respiratory

Due to

Respiratory

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles Dean
Address Church Hill Date signed Feb 29

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

RESIDENT OF COUNTY

RECEIVED
APR 29 1947
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 836

CERTIFICATE OF DEATH

Reg. Dist. No. 03142 2510

1. PLACE OF DEATH:

County Queen Anne's
 City or town Sudburyville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State MD County Queen Anne's
 City or town Sudburyville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Margaret Deborah Evans

3. (b) Social Security Number

none4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Nov 12, 1858 B. (c) If alive, give age _____ years8. AGE: Years 88 Months 4 Days 18 hrs. _____ min.9. Birthplace Sudburyville Md.
(Town, county, and state)10. Usual occupation Asst. in Dr. Office

11. Industry or business _____

12. Name William F. Evans13. Birthplace Centerville Md.14. Maiden name Angie Griffin15. Birthplace Centerville Md.16. Informant Mrs. Ruth EvansAddress Centerville Md.17. Burial Date thereof April 1, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium Sudburyville CemeteryLocation Sudburyville Md.18. Funeral director Edward FallowAddress Millington Md.19. April 1, 1947 Edgar L. Lane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 19 47 at 7:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 19 47 to July 30 19 47 and that I last saw him alive on July 30 19 47Immediate cause of death Cerebral Embolism DURATIONDue to Arterial SclerosisDue to Arterial SclerosisOther conditions Senility

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE W. F. Evans M. D. or otherAddress Sudburyville Md. Date signed 3/31/47

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APR 5 1947

BUREAU P. B.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03143 2510

1. PLACE OF DEATH:

County..... *Queen Anne's*
 City or town..... *W. Millington*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... *50 yrs*
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State..... *Maryland* County..... *Queen Anne's*
 City or town..... *W. Millington*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Thomas Hillis
 4. Sex..... *M* 5. Color or race..... *W* 6.(a) Single, married, widowed, or divorced..... *Single*

3. (b) Social Security Number

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... *Mar 5, 1865*

8. AGE: Years..... *81* Months..... *3* Days..... *25* If less than one day..... hrs. min.

9. Birthplace..... *Queen Anne's*
 (Town, county, and state)

10. Usual occupation..... *Farmers*

11. Industry or business.....

12. Name..... *John Hillis*

13. Birthplace..... *Germany*

14. Maiden name..... *Kate German*

15. Birthplace..... *Germany*

16. Informant..... *John D. Hillis*

Address..... *Wilmington, Md.*

17. *Burial* Date thereof..... *March 8, 1947*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... *Wilmington*

Location..... *Wilmington, Md.*

18. Funeral director..... *Edward Kellow*

Address..... *Wilmington, Md.*

19. *Mar. 7* 19 *47* *Edward D. Lane*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *March 5, 1947* at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....
Did not attend to.....

and that I last saw him..... on.....
March 5, 1947

Immediate cause of death..... *Acute Myocardial Infarction*

Acute Myocardial Infarction

Due to.....

Due to.....

Other conditions..... *Acute Myocardial Infarction*

(Include pregnancy within 8 months of death)

Major findings of operations..... *None*

Autopsy results..... *None*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

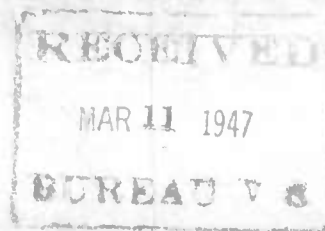
23. Signature..... *Edward D. Lane*

Address..... *Wilmington, Md.*

Date signed..... *Mar 7 1947*

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64.00

copy as I don't know of trip



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9-2-6)

03144

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County Green AnneCity or town Church Hill
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County 9.A.City or town Church Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary J. Mackey

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Daniel L. Mackeydeceased7. Birth date of deceased (mo., day, yr.) Unknown 18678. AGE: Years 80 Months _____ Days _____ If less than one day _____ hrs. _____ min. _____9. Birthplace Green Anne Co. Ind.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name James Slaughter13. Birthplace Ind.14. Maiden name Sarah Winsen15. Birthplace Ind.16. Informant Mr. James SlaughterAddress Fulton Del17. Burial Date thereof Mar. 27 47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Church HillLocation Church Hill Ind18. Funeral director Edgar L. LaneAddress Church Hill Ind.19. Mar. 25 47 Edgar L. Lane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 19 47 at 6 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about 9/1 19 47 to March 24 19 47 and that I last saw him alive on March 24 19 47Immediate cause of death Myocardial InfarctionDue to _____ DURATION 24

Due to _____

Due to _____

Due to _____

Due to _____

Other conditions Dehydration and(Include pregnancy within 3 months of death) Duration: not stated.Major findings of operations Cereb.

Date of op. _____

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ✓Means of injury ✓ Injured at work? ✓23. SIGNATURE Norman S. SlaughterAddress Church Hill Ind. Date signed March 24

RECEIVED STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
APR 29 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2510

1. PLACE OF DEATH:

County Queen Anne's
City or town Millington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
Egg running Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Kent.
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Harry Montgomery
4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19th 1947 at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18th 1947 to March 19th 1947 and that I last saw him alive on March 19th 1947

Immediate cause of death apoplexy DURATION 2 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE G. R. Cefeland M. D. or other _____

Address Millington Date signed Mar 22 1947

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug 22 1874

8. AGE: 72 Years 7 Months 25 Days If less than one day _____ hrs. _____ min.

9. Birthplace Altoona Pa.
(Town, county, and state)

10. Usual occupation Boat work

11. Industry or business _____

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Edward Kellour

Address Millington Md.

17. Burial Date thereof March 30 1947

(Burial, cremation, or removal, Which?) _____ (month) (day) (year)

Cemetery or crematory Millington

Location Millington Md.

18. Funeral director Edward Kellour

Address Millington Md.

19. 3-29 1947 Edgar R. Lane

(Date rec'd by registrar) _____ Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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Handwritten notes:
March 14 1947
March 14 1947
March 14 1947

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Handwritten notes:
March 14 1947
March 14 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 03146 2548

1. PLACE OF DEATH: *Queen Anne*
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *all life*
Hospital, institution, or street address where death occurred:
Grassville R.D. #1
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....*Maryland* County.....*Queen Anne*
City or town.....*Grassville*
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
Herbert Price O'Donnell

3. (b) Social Security Number
218-087-7151

4. Sex *M* 5. Color or race *W* B.(a) Single, married, widowed, or divorced *Married*
6.(b) Name of husband or wife.....*Clara C. O'Donnell*
7. Birth date of deceased (mo., day, yr.) *June 9 1914* B.(c) If alive, give age *40* years
8. AGE: Years *32* Months *9* Days *17* If less than one day.....hrs.min.

9. Birthplace.....*Grassville Queen Anne Ind.*
(Town, county, and state)
10. Usual occupation.....*Justice of Peace*
11. Industry or business.....*Local*
FATHER 12. Name.....*Omer O'Donnell*
13. Birthplace.....*Grassville Ind.*
MOTHER 14. Maiden name.....*Eliz E. Pratt*
15. Birthplace.....*Grassville Ind.*

16. Informant.....*Mrs. Clara C. O'Donnell*
Address.....*Grassville Ind.*
17. Burial.....*March 25 1947*
(Burial, cremation, or removal. Which?) Date thereof.....
(month) (day) (year)
Cemetery or crematory.....*Christyfield*
Location.....*Centerville Maryland*
18. Funeral director.....*Mary V. Williams*
Address.....*Christyfield, Ind.*
19. *March 24 1947* *Helen M. Aldridge*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*March 22 1947* at *2:45 P.*
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *March 9 1947* to *March 22 1947*
and that I last saw him alive on *March 22 1947*
Immediate cause of death.....*Tuberculosis of lungs*
Due to.....
Due to.....
Other conditions.....*T.B. of r. knee joint*
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?.....
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?
23. SIGNATURE.....*Theodor Sattelmuer U.I.*
Stevensville M. D. or other
Address..... Date signed *3/22/47*

MARGIN RESERVED FOR BINDING

VS A15 AT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF AGRICULTURE

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

MENTAL CONDITION

RECEIVED

MAR 28 1947

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *467*

CERTIFICATE OF DEATH

★ 03147
Reg. Dist. No. *2530*

1. PLACE OF DEATH:

County... *Queen Anne's*
City or town... *Centerville*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *22 years*
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... *Maryland* County... *Queen Anne's*
City or town... *Centerville*
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Maggie Blake Seney

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female colored married

8. (b) Name of husband or wife Daniel Seney

7. Birth date of deceased (mo., day, yr.) August 16-1898 6. (c) If alive, give age 67 years

8. AGE: Years Months Days If less than one day
48 6 19 hrs. min.9. Birthplace *Burrville 24 Co. Maryland*
(Town, county, and state)10. Usual occupation *Housework*

11. Industry or business

12. Name *Henry Blake*13. Birthplace *Queen Anne's Co. Maryland*14. Maiden name *Annie*15. Birthplace *Queen Anne's Co. Maryland*16. Informant *Daniel Seney*Address *Centerville, Maryland*17. *Burial* Date thereof *March 7-47*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Burrville*Location *Burrville 24 Co. Md*18. Funeral director *Barton Bros*Address *Centerville, Maryland*19. *Mar 7-47* *Clair Centerville*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Mar. 5* 19 *47* at *6:40* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 14 19 *45* to *Mar. 5* 19 *47*
and that I last saw him alive on *Mar. 4* 19 *47*Immediate cause of death *Prostate**Obstruction*

DURATION

Due to

Due to *Obstruction of**Prostate*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ☒ Date of

Where did injury occur? (City or town) (County) (State)

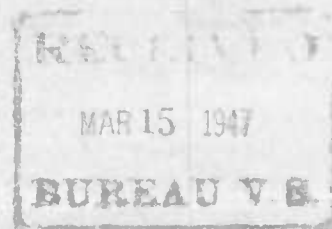
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *H. J. Westerman*

M. D. or other

Address *Centerville, Md* Date signed *3/7/47*



2-33-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-E

CERTIFICATE OF DEATH

Reg. Dist. No.

03148

2520

1. PLACE OF DEATH:

County Queen Anne's
 City or town Centerville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? about all his life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne's
 City or town Centerville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

William James Sennett

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Rafa Porter Sennett

7. Birth date of

deceased (mo., day, yr.)

June 3 - 1859

6. (c) If alive, give age

53 years

8. AGE:

Years

87

Months

9

Days

24

If less than one day

hrs.min.

9. Birthplace

Queen Anne's Co Maryland
(Town, county, and state)

10. Usual occupation

Farming

11. Industry or business

FATHER
MOTHER

12. Name

Slip T Sennett

13. Birthplace

Maryland

14. Maiden name

Don't know

15. Birthplace

Don't know

16. Informant

Mrs Rafa P. Sennett

Address

170 Centerville Maryland

17.

(Burial, cremation, or removal. Which?)

Date thereof

March 28-47
(month) (day) (year)

Cemetery or crematory

Chesterfield

Location

Centerville Maryland

18. Funeral director

Barton Bros

Address

Centerville Maryland

19.

(Date rec'd by registrar)

Mar 28-47Eileen Armstrong

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 19 47 at 8³⁰ P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 25 19 47 to March 27 19 47and that I last saw him alive on March 27 19 47

Immediate cause of death

For salmonella related
spontaneous pulmonary
thrombosis

DURATION

Due to

Due to

Other conditions

Smoking

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. S. Barton MD

M. D. or other

Address

Centerville MDDate signed 3-28-47

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SEP 5 1947

BUREAU 8

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03149

Reg. Dist. No. 2510

1. PLACE OF DEATH:

County Queen Anne's
 City or town near Mc Shinn's Corner
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Queen Anne's
 City or town near Mc Shinn's Corner
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Clinton Sparks

3. (b) Social Security Number

4. Sex male 5. Color or race White 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Edna Sparks7. Birth date of deceased (mo., day, yr.) December 19 - 18916.(c) If alive, give age 44 years8. AGE: Years 55 Months 3 Days 10 If less than one day _____ hrs. _____ min.9. Birthplace Queen Anne's Co. Ind.
(Town, county, and state)10. Usual occupation factory worker

11. Industry or business _____

12. Name Wm. Sparks13. Birthplace Maryland14. Maiden name Emma Sparks15. Birthplace Maryland16. Informant Mrs. Edna SparksAddress Chestertown Ind. R.F.D.17. (Burial, cremation, or removal. Which?) Burial Date thereof April 2 - 1947
(month) (day) (year)Cemetery or crematory CrumptonLocation near Crumpton18. Funeral director Edgar H. LaneAddress Church Hill Ind.19. April 4 1947 Edgar H. Lane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947 at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1947 to March 28 1947
 and that I last saw him alive on March 28 1947

Immediate cause of death

Patting Strokes

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. R. Cofelord M.D.Address Baltimore M. D. or other _____Date signed April 1 - 47

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

021

NOTATION

Handwritten notes:
100-11-25-100
100-11-25-100
100-11-25-100
100-11-25-100

RECEIVED
APR 5 1947
BUREAU 3

1-35

Handwritten notes:
100-11-25-100
100-11-25-100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03150

Reg. Dist. No. 2510

1. PLACE OF DEATH:

County Queen Anne's Co.City or town near Barclay
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary'sCity or town near Barclay
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Bertie Willis

3. (b) Social Security Number

Wallis4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Hugh Wallis8. (c) If alive, give age 72 years7. Birth date of deceased (mo., day, yr.) October 23 - 18788. AGE: Years 68 Months 5 Days 5 If less than one day _____ hrs. _____ min.9. Birthplace Kent Co. Md.
(Town, county, and state)10. Usual occupation housework

11. Industry or business

12. Name Marion Wallis13. Birthplace Kent Co. Md.14. Maiden name Martha Elizabeth Bramble15. Birthplace Kent Co. Md.18. Informant Miss Mary WallisAddress Queen Anne's Co. Md.17. Burial Date thereof 3-31-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ChestertownLocation Chestertown Md.18. Funeral director Edgar L. LaneAddress Church Hill Md.19. 3-28 1947 Edgar L. Lane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1947, at 1-9 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 to March 26 1947and that I last saw him alive on March 26 1947Immediate cause of death Cerebral Hemorrhage 7 days

DURATION

Due to Hypertension 1946Due to Arteriosclerosis 1944

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank W. Smith
M. D. or other _____Address Chestertown Date signed 3/28/47

RECEIVED

APR 2 1947

BUREAU 8

1-35✓

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

03151

Reg. Dist. No. 251

1. PLACE OF DEATH: Queen Anne's
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Melvin Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME Charles J. Willoughby

3. (b) Social Security Number none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb. 28 1883 6. (c) If alive, give age..... years

8. AGE: 64 Years 0 Months 23 Days If less than one day..... hrs. min.

9. Birthplace..... Md. (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name S. D. Willoughby

13. Birthplace Md.

14. Maiden name Martha F. Beachamp

15. Birthplace Md.

16. Informant C. A. Brampton

Address Stevensville Md.

17. Burial Date thereof March 26 1947 (Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Stevensville

Location Stevensville Md.

18. Funeral director Edward H. Lowe

Address Millington Md.

19. 3-25 47 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1947 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 1947 to July 23 1947 and that I last saw him alive on July 19 1947

Immediate cause of death

Primary occlusion

Due to Corary Sclerosis

Due to Chronic Myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. D. Willoughby M. D. or other

Address Edgemoor Md. Date signed 3/25/47

MARGIN RESERVED FOR BINDING

VS A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 2 1947

BUREAU OF

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 199

CERTIFICATE OF DEATH

Reg. Dist. No. 2530

1. PLACE OF DEATH

County Prince George'sCity or town Landover
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5292070Hospital, institution, or street address where death occurred:
NoneHow long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For unborn infants, give residence of mother)

State Maryland (County) Prince George'sCity or town Landover
(If outside city or town limits, write RURAL and give nearest town)Street No. None
(If rural, give LOCATION)2.(c) If veteran, name war None

3. (a) FULL NAME

Henry Wright

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife None6. (c) If alive, give age 47 years7. Birth date of deceased (mo., day, yr.) May 21, 18958. AGE: Years 49 Months 18 Days 18 hrs. None min. None9. Birthplace Landover, Md.
(Town, county, and state)10. Usual occupation Electrician11. Industry or business Electrician12. Name Henry Wright13. Birthplace Landover, Md.14. Maiden name None15. Birthplace Landover, Md.16. Informant Charles Lee, Jr.Address Landover, Md.17. Burial March 12, 1947

(Burial, cremation, or removal? Which?)

Date thereof March 12, 1947
(month) (day) (year)Cemetery or crematory BethesdaLocation Chester18. Funeral director Louis A. HenryAddress Cambridge, Md.19. March 18, 1947

(Date rec'd by registrar)

Elizabeth H. Hester
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1947 at 12:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12, 1947and that I last saw March 12, 1947 alive on March 12, 1947Immediate cause of death Myocardial infarction

DURATION

Medical history, known to meDue to Myocardial infarctionDue to Myocardial infarctionOther conditions Myocardial infarction

(Include pregnancy within 8 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of NoneWhere did injury occur? None (City or town) (County) (State)Injured at home, farm, industry, public place (where?) NoneMeans of injury NoneInjured at work? None23. SIGNATURE Howard S. DredgerM. D. or other NoneAddress Landover, Md. Date signed March 14, 1947Deputy Medical Examiner

RECEIVED

MAR 21 1947

BUREAU

1-35